**KENTUCKY BOARD OF DURABLE MEDICAL EQUIPMENT SUPPLIERS**
**APPLICATION FOR HOME MEDICAL EQUIPMENT LICENSE OR RENEWAL**

If necessary, attach additional pages to fully answer each question. A license expires on September 30 two (2) years following its date of issuance.

1. License type: ☐ New license ☐ Renewal ☐ Reciprocal license or renewal

2. Business name that shall appear on the license:_____

3. Address of premises to appear on license: _____

_____

State:_____Zip:_____

(The license must be displayed at this address)

4. Tax ID Number:_____

5. Business type: ☐ Sole Proprietor or Partnership ☐ Corporation or LLC

6. Phone number for licensed premises:_____

7. Business hours for licensed premises:

S: _____M:_____T: _____W: _____Th: _____F: _____S: _____

8. If applicable, emergency phone number provided to consumers:_____

If the business is a partnership, please provide the information requested in Questions 9, 10, 11, and 12 for all partners. If the business is a Corporation or LLC, please provide the information requested in Questions 9, 10, 11, and 12 for all officers.

9. Name:_____ Title:_____

10. Mailing address:_____

11. Phone number:_____ 12. Primary email address:_____

If you answer "Yes" to Questions 13 through 18, provide the jurisdiction, date, circumstances, and disposition and penalty for each conviction, Alford plea, or plea of nolo contendere.

13. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to a sex crime as defined in KRS 17.500? ☐ No ☐ Yes

14. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to a criminal offense against a victim who is a minor as defined in KRS 17.500? ☐ No ☐ Yes

15. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to a felony offense under KRS Chapter 209? ☐ No ☐ Yes

16. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to an offense which would classify you as a violent offender under KRS 439.3401? ☐ No ☐ Yes

17. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to any felony charge? ☐ No ☐ Yes

18. Have you or any owner of the business ever violated the home medical equipment laws, rules, or administrative regulations of this state, any other state, or the federal government? ☐ No ☐ Yes

19. Below, please check the appropriate boxes depending on whether you are applying for an Initial License, Renewal License, or a Reciprocal License. If you are renewing a reciprocal license, please choose "Reciprocal License or Renewal."

☐ **A. INITIAL LICENSE.** In support of my application for a license, I agree to pay the $350 license fee. I further swear or affirm that:

☐ I am accredited by _____, a national accreditation organization approved by the Centers for Medicare & Medicaid Services that accredit suppliers of durable medical equipment. A copy of that accreditation is attached; or

The business is an Exempt Profession per section 1848 (k) (3) (B) and the following is the eligible professional practitioner category that applies to our business license _____. {Provide profession name, attach or upload letter stating Exempt profession/practitioner status); or

Because you do not possess a current valid CMS approved accreditation or a CMS Exemption, please upload / attach the most recent Kentucky or home state Pharmacy Board inspection form. Please provide an **Inspection Form within one year of today's date.** I understand and agree future inspections may be required to maintain the license and shall be paid by the business license holder per 201 KAR 47.010 and 47.020.

☐ I can comply with the requirements of KRS Chapter 309.400 through 309.422 and 201 KAR Chapter 47 and request an inspection be performed of the premises listed above within 60 days of this application.

**NOTE:** ☐ If this initial application is required due to a change of address, please provide your previous license number issued by the Board:_____.

☐ **B. RENEWAL LICENSE.** In support of my application for a license renewal, I agree to pay the $350 renewal fee. I further swear or affirm that:

☐ I am accredited by _____, a national accreditation organization approved by the Centers for Medicare & Medicaid Services that accredit suppliers of durable medical equipment. A copy of that accreditation is attached; or

The business is an Exempt Profession per section 1848 (k) (3) (B) and the following is the eligible professional practitioner category that applies to our business license _____. {Provide profession name).

I can comply with the requirements of KRS 309.400 through KRS 309.422 and 201 KAR Chapter 47.010 and 47.020; or

Because you do not possess a current valid CMS approved accreditation or a CMS Exemption, please upload / attach the most recent Kentucky Pharmacy Board inspection form. Please provide an **Inspection Form within one year of today's date.**

I can comply with the requirements of KRS 309.400 through KRA 309.422 and 201 KAR 47.010 and 47.020 and I understand and agree future inspections may be required to maintain the license and shall be paid by the business license holder per 201 KAR 47.010 and 47.020.

☐ I can comply with the requirements of KRS Chapter 309.400 through 309.422 and 201 KAR Chapter 47 and request an inspection be performed of the premises listed above within 60 days of this application.

☐ **C. RECIPROCAL LICENSE OR RENEWAL.** In support of my application for a reciprocal license, I agree to pay the $350 reciprocal license fee or reciprocal license renewal fee. I further swear or affirm that:

☐ I am licensed to provide home medical equipment and services in the state(s) of _____. I have attached a certified copy of my license.

☐ No other state of licensure has issued or taken any disciplinary or regulatory licensing action. If my any state of licensure has issued or taken any disciplinary or regulatory licensing action, I have provided a copy of my disciplinary or licensing history and attached an explanation.

**20. CERTIFICATION BY APPLICANT.** I certify that the information provided in this application is true and accurate and that I have read and understand the provisions of KRS Chapter 309.400 through 309.422 and 201 KAR Chapter 47 and that the licensee will comply with those provisions. I understand and agree that I will notify the Kentucky Board of Durable Medical Equipment if there is any change in the information provided in this application.

I also give the Board my consent to conduct a criminal history background check or to obtain my credit history and to provide the information necessary for the Board to conduct a criminal history background check or to obtain my credit history.

**SIGNATURE** **TITLE** **DATE**

**Please make checks payable to:**
**Kentucky State Treasurer**

**Mailing Address:**
**KY Board Durable Medical Equipment Suppliers**
**P.O. Box 1360**
**911 Leawood Drive**
**Frankfort KY 40602**

Instructions and Important Changes to Renewal Licenses

Initial applications will be processed in our offices. {Online renewal ended September 30,2016} Once completed, the email address provided on the application will receive an email notifying you of your approval and you will be able to then through our eService Account print your certificate. You will receive in two separate emails your USER name and then a Password for your account.

**$ 350.00 initial or renewal fee** covers 2 year licensing period unless you change ownership or premise/location. Please make the Check Payable to: *Kentucky State Treasurer*. KY Board Durable Medical Equipment Suppliers P.O. Box 1360 911 Leawood Drive Frankfort KY 40602

1. **Proof of an approved CMS Accreditation** Certificate must be attached or uploaded with the application. The expiration of the accreditation must exceed September 30th of the application year. Any application without a valid accreditation will not be issued until such valid accreditation is received. Exempt profession/practitioner to CMS accreditation status letter may be used if valid. Inspection by Pharmacy Board of other state agency empowered by home state to inspect or regulate HME companies.
2. **Applications without valid Accreditation shall be subject to an inspection and** the cost of said inspection will be the responsibility of the applicant and must be paid prior to the inspection to the KBDMES. Cost is $ 350.00 per inspection. Failure to meet an inspector will result in additional inspection fee and forfeiture of the original inspection fee. The license shall not be issued until successful completion of inspection under KRS 309 and 201 KAR 47:010 and 47:020.
3. **New License Number will be issued** for every license. Your current HME-00000 number will be shown on your certificate, card or online verification page at O&P and will be called your LEGACY LICENSE NUMBER. It will show status identical to your new number. O&P will if necessary, provide you with a letter stating it is valid, current and reflects the status of your new license number. In your e Service Account you will be able to print off your required business certificate.
4. **Change of Ownership or location/premise** now requires immediate notification and new application under KRS 309 and must include a new $ 350.00 fee. The licensing period starts anew, meaning you may have greater than a twenty four month licensing period and the new renewal date will be reflected online and in the system.

https://oop.ky.gov/Eservices/Default.aspx

Thank you for your patience.
Larry Brown Executive Director email Larry.Brown@ky.gov